501. Attachment L-2 refers to Section J-4, Document XX. There is no such document. Also, there is no description/definition of a "Geographic Area" in the RFP, as that term is used in Section B. Is Alaska included in Geographic Area 11 or Geographic Area 9/10/12?

RESPONSE: The incorrect reference in Attachment L-2 was corrected with Amendment 0001. Alaska is included in Geographic Area 11.

502. Attachment L-3 section 5.3.2 discusses the MTF Commander survey. What will the government do to ensure adequate response to ensure survey validity? Award fee determination is dependent on adequate response. Will the government consider a non-response as positive since human nature is to ensure response when there is something negative and to not respond unless there is a problem to raise?

RESPONSE: All Commanders are required to respond; a non-response is not acceptable. A not applicable response could be considered, as an example, a new commander not had an opportunity to bring any issues to the attention of the contractor (DRD/MTF survey questions 4 and 5).

503. Attachment L-3 section 6.2 states " … performance guarantee amount stated in the Schedule." Since there is no Schedule included in the Attachment L-3 document, is it to be assumed the Schedule referred to is Schedule B in the Cost Proposal, or should the reference to the Schedule actually refer to Section H-8.c? . Please confirm.

RESPONSE: The Schedule includes Sections A through H, but not Sections I through M. In this case, the performance guarantee amounts are identified in H-8.

504. Attachment L-3 Survey Methodology page 1, refers to Healthcare Service Records (HCSR). Are HCSR and TEDS both to be used? Please clarify.

RESPONSE: No. The attachment will be changed in the next amendment from HCSRs to TEDs.

505. Attachment L-3 TRICARE Purchased Care Contractor Support Survey, page 2 item 2. states "TRICARE Customer Service Centers (TCSC) – The TCSC is …" Does the government intend to change the name of the TRICARE Service Centers (TSC) or is this a different/new service center? Please clarify.

RESPONSE: The attachment will be changed in the next amendment to reflect the correct term, TRICARE Service Centers (TSCs)

506. Attachment L-3 TRICARE Purchased Care Contractor Support Survey and Survey Methodology states that a response pool of 400 will be used. Since individuals may refuse to answer for any number of reasons, not the least of which may be that they feel their privacy has been violated by someone knowing they used services, will the government consider a non-response as positive since human nature is to ensure response when there is something negative and to not respond unless there is a problem to raise?

RESPONSE: No. The presence and direction of bias associated with response has not been clearly established and certainly not in this survey. Although the argument exists that those with negative opinions are more likely to respond, the privacy issue

mentioned in the same sentence indicates how unclear bias, if any, may effect results. If privacy sensitivity promotes non-response one could argue that you are less likely to complain or criticize if anonymity is not protected. The final data would, in that case, over represent positive opinions. Therefore, for a non-response, we will continue to survey until the 400 pool is reached.

507. RFP Section L, Attachment L-3 Award Fee Plan Managed Care Support Contract, Section 6, Contractual Award Fee Requirements 6.1 States "…."When determining the award fee, the AFDO will consider the Government's survey data and all other information he/she deems appropriate." Can the Government provide examples of the types of 'other information' that might be deemed appropriate? Would this be a reference to 5.5 of this section that states " …as well as any mitigating factors which may have affected contractor performance," or are there other indicators of performance the AFDO may consider? Please explain.

RESPONSE: Examples include staff input, contractor input, input from beneficiary organizations, etc.

508. RFP Section L, Attachment L-3 Award Fee Plan Managed Care Support Contract, 7. Award Fee Determination 7.1 States "The award fee pool consists of three components, beneficiary satisfaction, MTF Commander Satisfaction, and Regional Director Satisfaction." Are all three of these indicators of satisfaction weighted equally? If not, how will the three components be weighted, and what calculation will be used by the Government to determine the award fee pool payable on a quarterly basis?

RESPONSE: There is no weighting. The Award Fee determination is a subjective decision by the AFDO upon recommendation of the Award Fee Board taking into consideration the survey results, current performance and the board members' knowledge about the performance of the contractor.

509. RFP Section L, Attachment L-3 Award Fee Plan Managed Care Support Contract. The Deputy Regional Director(DRD)/MTF Commander Quarterly Survey has six areas to be evaluated separately. The TRICARE Purchased Care Contractor Support Survey identifies five areas to be considered for evaluation by the beneficiary as a whole, rather than evaluate each area separately. Would the Government consider modifying the beneficiary survey to allow the beneficiary to evaluate satisfaction in each of the five areas?

RESPONSE: No. The government prefers to rely on a global assessment of satisfaction that allows the beneficiary to develop his/her internal measure of relative importance for all areas of MCS support. This one item survey makes it most likely that we can get useful, reliable information on satisfaction in a timely, cost effective way that avoids imposing relative values, or weights, to these important topics or areas of support.

510. Attachment L-3 Survey Methodology indicates that the sample for the survey will be drawn from a list of outpatient purchased care visits. Some of the five areas identified for consideration by the beneficiary will not necessarily be applicable for the outpatient visit included in the sample. For instance a claim and/or an encounter for laboratory services. How will this be factored in the survey results?

RESPONSE: The sample will be drawn from outpatient purchased care services. Please note that the 5 areas are those that the survey firm will ask the beneficiary to consider. It is very unlikely the beneficiary will take into consideration any laboratory claim as they are usually not aware of the laboratory claim until EOB receipt.

511. Attachment L-3 Survey Methodology provides the methodology for only the beneficiary satisfaction survey determination. It indicates that the percentage of satisfied responses will be used to determine whether the contractor has met the minimum standard for an award. What methodology and standard will be used in assessing the results of the DRD/MTF Survey?

RESPONSE: Attachment L-3 does provide for the MTF and Regional Director's in put as to satisfaction with the contractor's performance. There is no mention using this instrument to measure the meeting the minimum standards and the only mention of percentages is in the description of the sample size. The award fee is a subjective judgement and not based on specified percentages. The award fee determining official (AFDO) will base his/her judgement on the surveys and any other information deemed appropriate by the AFDO.

a. Will each of the six areas be reviewed and weighted separately?

RESPONSE: No

b. How will those results 'roll up' to determine overall achievement by the contractor?

RESPONSE: Please refer to the previous response.

c. A follow-on question: As is typical with most customer satisfaction surveys, the TRICARE Purchased Care Contractor Support Survey provides the choice of a neutral response, "neither satisfied nor dissatisfied." Would the government consider including a similar choice on the DRD/MTF Survey?

RESPONSE: No. See response to question 502.

512. Section L.12.f..(4)(2) page 89. (Beginning with this subsection, lettering changes to numbering.) Are offerors directed to use the Government provided estimates in Section B for these CLINs and extend the amount to the amount column? Please explain.

RESPONSE: Yes

a. Related question, this subsection states in part, "The fee … shall not exceed ten percent (10%) of the estimated contract cost for this CLIN …." Does this cost refer to the Government provided estimate, the offeror's own estimate, or the amount proposed in Section B (if different)?

RESPONSE: In section L.13.f.(4)(j) the estimated contract cost is the Government estimate provided in Section B.

513. Section L.12.g(4) (g), page 90 Health Care Prices. Does the Government have any projections of MTF workload during any or all of the Option Periods of the contracts? If so, please provide them in as much detail as is available.

RESPONSE: The Government did not make any projections. Please refer to the historical data in the data package for the MTF workload.

514. Section L.12.g (4)(g)(4) page 90. What is the relevance of "assumptions regarding the number of MHS-eligible beneficiaries" in explaining, justifying, or evaluating the proposed health care price?

RESPONSE: The Government will review the offeror's proposed target health care costs for Option Period I and evaluate all pricing factors considered by the offeror in developing the proposed target health care costs. Therefore, the offeror's assumptions regarding the number of MHS-eligible beneficiaries are relevant to the evaluation.

515. Section L.13.a., page 90. Award Fee. It seems that if the government believes that Offeror ABC will not achieve its award fee, and in fact will have its administration price reduced (through the performance guarantee), then the government could conclude that Offeror ABC will be a better buy than an offeror whose performance is expected to be better than Offeror ABC's. In the evaluation process, there appears to be a reward to an offeror whose performance is expected to be worse, and conversely, a punishment for an offeror whose performance is expected to be better. How will an offeror's bid performance guarantee amount affect the evaluation of that offeror's proposal?

RESPONSE: The proposed performance guarantee amounts and the correlating award fee pool amounts will not be included in the technical and cost/price evaluation. We anticipate clarifying this in an Amendment.

516. Section L.14 page 91. This section states "Neither the contractor, nor the Government shall assume any resource sharing savings in conjunction with the development of option period 1 target costs for the contract". The historical data provided in Section J, Attachment 8 contains implied savings resulting from those Resource Sharing projects that were operational during the reporting period.

a. In the evaluation process, how does the Government intend to estimate the additional costs that would occur if no Resource Sharing is assumed?

RESPONSE: All existing projects terminate. As stated in Amendment 0002 the government expects to provide resource to the MTFs to continue investment opportunities. The Government will not evaluate the impact of offeror assumptions or estimates with regards to resource sharing.

b. Will the Government provide an estimate, by current contract region, of the additional costs that would have occurred had there been no Resource Sharing projects in the historical data reporting periods? This could be accomplished by providing the total Resource Sharing expenditure and the overall savings ratio for each current contract region.

RESPONSE: Available data was provided in Amendment 2.

517. RFP Attachment L-8 - Please provide the estimates of MHS-eligible beneficiaries by current contract Region. Note that this is essential if health care delivery in Option Period I under this solicitation begins at different times by Region.

RESPONSE: Attachment L-8 is being updated for release in an upcoming amendment.

a. What is the date of the Non-TRICARE/Medicare dual eligible CHAMPUS beneficiary estimates on this Attachment?

RESPONSE: The estimate was based on the May 2002 DEERS report.

b. Does the Government estimate that the CHAMPUS beneficiary numbers, like the MHS-eligible counts, also will remain constant through Option Periods II-V? If not, please provide the figures at the level of detail requested above for MHS-eligible beneficiaries.

RESPONSE: The Government is revising these estimated and will release the revisions in an upcoming amendment.

518. Section M.2 on Page 92 indicates that the government will evaluate offers for award purposes "by adding the total price for all options to the total price for the basic requirement." Section M.2 appears to conflict with the evaluation process stated in Section M.8 on Page 95. Additionally, is the "basic requirement" term as used in Section M.2, mean the "Base Period" as defined in RFP Section B? Please clarify.

RESPONSE *Revised 13 December 2002*

RESPONSE: The term "basic requirement" does pertain to the "base period". We disagree that there is a conflict between M.2 and M.8/M.9. The Government will not amend Section M.2 of the RFP given that this is an approved FAR clause deviation that is merely a summary (and not intended to restate the rest of Section M) concerning the exercise of options. Section M.8 (a) and (b) address the evaluation process and note that total evaluated price will consist of all proposed administrative support service prices and health care services underwriting fees for all option periods.

519. Section M.7.c on Page 94 states (in the sixth line and also in the eleventh and twelfth lines) that a past performance rating will be based on "the amount of past performance". Is the amount of past performance that will be considered limited to the last three years, as stated in Section L.12.f.(2)(b) on Page 87?

RESPONSE: Yes. Please refer to the response to Question 493.

520. Section M.5.a, page 93. Although relative weighting of evaluation factors is noted, no specific weights are supplied. What is the specific weighting of the evaluation subfactors (e.g. 25% for subfactor 1, 22% for subfactor 2, etc.)?

RESPONSE: No percentages will be established.

521. Section M.5.c page 93. Is there a percentage range, or other more specific quantitative measures that defines the phrase "essentially equal"?

RESPONSE: The phrase "essentially equal" cannot be quantitatively defined. It is within the discretion of the Source Selection Official (as part of the best value determination process) to determine that certain proposals (or aspects of certain proposals) are "essentially equal" when considering overall value to the Government. The Source Selection Official is given broad discretion in making such a determination, as long as such a decision is supported by a rational basis.

522. Section M.8. page 95 (preamble). This section states in part, "The highest proposed price for transition out services will be included in the total evaluated price." Does this refer to the highest among the contract Option Periods, among offerors, or another set of prices? Please explain.

RESPONSE: The proposed prices for transition-out effort for each of the five option periods will be compared, and the highest price, unique to that offeror, will be used in calculating the offeror's total evaluated price.

a. A related question: Please define the term "unbalanced pricing". What are the consequences of a finding of unbalanced pricing?

RESPONSE: In accordance with FAR 15.404-1, unbalanced pricing exists when, despite an acceptable total evaluated price, the price of one or more contract line items is significantly over or understated as indicated by the application of cost or price analysis techniques. An offer may be rejected if the contracting officer determines that the lack of balance poses an unacceptable risk to the Government.

523. Section M.8.a.(1)-(6) page 95. Please describe how the Government will determine whether each proposed price is "reasonable." Does any "unreasonable" price for any CLIN disqualify an offeror from being awarded a contract?

RESPONSE: The determination of price reasonableness is accomplished in accordance with FAR 15.404. A finding that one particular line item is considered "unreasonable" in price may not preclude the Government from making an award to that offeror. However, if it is determined that the overall offer is unreasonably priced, the contracting officer is precluded from selecting that offeror for award.

524. Section M.8.a.(2) page 95. Beyond the limitation stipulated in Section L.12.f.(3) (2) [*sic*] on page 89, please explain how the fixed fee can be deemed unreasonable.

RESPONSE: The Government has determined that, for purposes of this RFP, if an offeror were to propose a fixed fee percentage in excess of 10 percent of the Government-estimated case management/disease management costs, the resultant fee amount will be considered unreasonable.

525. Section M.8.b. (1) page 95. Is there a difference between "the Government's best estimate of the cost … that is most likely to result" and the cost that has been justified (as described in Section L.12.g.(3) [*sic*]). For example, if an offeror submits no information supporting anticipated provider discounts, no discount has been justified, but this is not the most probable result if the contract is awarded. Please explain this thoroughly.

RESPONSE *Revised 20 December 2002*

RESPONSE: The Government will review the offeror's target health care cost development. This will include a review of the pricing assumptions/factors used by the offeror. Enough information should be provided by the offeror to enable the Government to determine whether the assumption/factor is realistic. It is possible that some of the assumptions/factors used by the offeror might be considered by the Government to be unrealistic. If the Government disagrees with the justification of an assumption/factor provided by an offeror and determines that the proposed value is unrealistic, an adjustment will be made to the factor and reflected in the Government's probable cost calculation. In other words, lack of justification for an assumption will not automatically result in a cost-realism adjustment, unless the Government concludes that the proposed assumption/factor is unrealistic.

a. Has the Government made independent estimates of factors that are expected to influence costs but are outside the contractor's control?

RESPONSE *Revised 20 December 2002*

RESPONSE: Yes.

b. Will the same estimates be used for all offerors regardless of the justification submitted in support of the offerors' assumptions?

RESPONSE *Revised 20 December 2002*

RESPONSE: Yes, but for evaluation purposes only.

c. If so, what are these factors?

RESPONSE *Revised 23 December 2002*

RESPONSE: At a minimum, the cost elements that will be normalized include MTF workload, the number of eligible beneficiaries, and price inflation. These elements are detailed in Section L.14.f.(4)(i)[1] of the RFP. The use of the abbreviation "i.e." in the referenced section was changed by solicitation amendment 0009 to read "for example". The intent of the abbreviation change is to allow the Government flexibility to make determinations that other cost elements may be considered uncontrollable and adjusted accordingly, depending on the circumstances of an offeror's cost buildup.

526. Section M.8.b.(3) page 95. Beyond the limitation stipulated in Section L.12.g.(2) [*sic*], please explain how the target underwriting fee can be deemed unreasonable. Will the proposed fee percentages or fixed dollar amounts be so evaluated?

RESPONSE: The fee percentages and the fixed dollar amounts will be evaluated for reasonableness. Only the fixed-dollar underwriting fees will be included in the probable cost for Option Period I or the total evaluated price. The underwriting fee percentages will be determined unreasonable and unallowable if the fee percentages that are proposed are greater than 10 percent of target health care costs. The

Government expects consistency between the proposed fee percentage and the proposed fee amount.

527. Both Section M.2 on Page 92 and Section M.8 on Page 95 indicate that the total evaluated price for an Option Period would include the price for the Customer Satisfaction Award Fee Pool (CLIN 0106, etc.)? If the price for the Customer Satisfaction Award Fee Pool is included in the evaluation, isn't the offeror being placed at a competitive disadvantage (i.e., penalized) by proposing a high performance guarantee and, therefore, a correspondingly high award fee since, pursuant to Section L.13.b, "the amount of the award fee pool will be the same amount pledged by the offeror as a performance guarantee, up to 10%"? If the price for the Customer Satisfaction Award Fee Pool is included in the evaluation, how will the Government evaluate the probable amount to be paid under those CLINs?

RESPONSE: The customer satisfaction award fee pool CLINS will not be evaluated as part of the cost/price of an option period. We will clarify Section M.8 by an Amendment to the RFP.

528. Section H.1.b.(2) (b) page 45.
a. Please describe the proposal the contractor must submit in greater detail. For instance, would a simple letter be sufficient to meet the requirement?

RESPONSE: The contractor should submit a proposal with sufficient support to validate his new target cost. If the contractor believes that a letter is sufficient then they may send one.

b. May the Government and the contractor agree to extend negotiations beyond the specified time frame (*viz.*, 30 days before the start of the next Option Period)?

RESPONSE: By mutual agreement between the Government and the contractor, the negotiations may be extended. The target health care cost for the next Option period must be established by the start of the option period.

c. This section states "Once the target cost for the next year is established, the only adjustments that would be made for that year would be for negotiated health care changes, definitized health care change orders, other equitable adjustment health care change orders issued after the completion of the negotiations that affect the year just negotiated". Would an adjustment to the target cost be made for a health care change order that had been issued but not negotiated/definitized prior to the completion of the negotiations for the next option period target cost?

RESPONSE: No. Adjustments to target cost will be made for changes orders only when the change order is definitized.

529. Section H.1.b.(2) (b) page 45. The RFP states that if the contractor and the government cannot successfully conclude negotiations in time, then the Option Period II target health care costs will be based on "actual underwritten CHAMPUS health care costs" during Option Period I. Will the Option Period I costs, used in this formula, include health care costs in Option Period I that were not underwritten by the contractor, due to the phased in health care start dates? If another method is used, please describe.

RESPONSE: Yes. See the response to Q. 315.

530. Section H.1.b.(2) (c). page 46 What is the "national trend factor for underwritten CHAMPUS health care costs" referred to in this section? Does it currently exist? If so, is it publicly available?

RESPONSE: The national trend factor is the percent change in CHAMPUS cost from the prior option through the current option as described in section H.1 b.2.c. Please refer to slide 12 from Captain Tinling's briefing at the Pre-Proposal Conference available on the website. See also the responses to Q. 76, Q. 317, and Q. 611.

531. Section H.1.b.(2) page 46 (second 2). Is the term "profit percentage" in the last sentence of this paragraph the same thing as "underwriting fee percentage"? Also, the paragraph number and subsequent numbers are incorrect, since H.1.b(2) is also used on Page 45.

RESPONSE: No. Profit percentage refers to the profit for the negotiated health care change orders and other health care equitable adjustments and it is the same number as was proposed in the first option period for the underwriting fee percentage.

The paragraph numbering has been corrected.

532. Section H.1.b.(4)(c) page 46. In this section, it is clear that IBNR will be added to the estimate of Actual Cost for partial fee determination, but IBNR is not mentioned in final fee determination. In the final fee determination, will IBNR be used in the calculation of Actual Cost?

RESPONSE: Yes. A Government estimate of IBNR will be used.

533. Section H.8.h page 50. The standard is stated as "100% of all claims." Should that be "100% of "excluded claims"?

RESPONSE: It is 100% of excluded claims; please see the title to Section H-8h.

534. We assume under subsection L.11.c that an entity is eligible to serve as a subcontractor in more than one Region. Is this correct? We also assume that an entity that is serving as a subcontractor only is eligible to serve as a subcontractor underwriting health care risk in more than one Region. Is this correct?

RESPONSE: The answer is yes to the first question. Regarding the second question: In a future amendment to the RFP, the Government intends to replace the language contained in L.12.c with the replacement language provided in the response to question #11. (Note that L.11.c was renumbered to L.12.c. by Amendment 0001.)

535. We assume under subsection L.11.c that an Offeror who is awarded a Prime contract in one Region is eligible to serve as a subcontractor in another Region. Is this correct?

RESPONSE: Yes

536. Under the scenario in a questions 535 below, can that Offeror who is awarded a Prime contract in one Region and a subcontract in a second Region assume some portion of health care risk in the second region through its subcontract arrangement with the Prime? If so, what portion of health care risk would be acceptable?

RESPONSE: Please see the response to Question # 11.

537. We assume under subsection L.11.c that an Offeror who is awarded a Prime contract in one Region is eligible to serve as a subcontractor in another Region. Is this correct?)

RESPONSE: This is a repeat of question 534

538. If the scenario presented in question 537 below is not acceptable, is it acceptable for an Offeror to submit a bid as Prime in one Region and subcontractor (with a small protion of health care risk) in another Region with the proviso that the subcontract would be subject to modification to eliminate the health care risk piece if the Offeror was the successful Prime in the other Region?

RESPONSE: Please see the response to Question # 11

539. Under the scenario in question 538 below, can that Offeror who is awarded a Prime contract in one Region and a subcontract in a second Region assume some portion of health care risk in the second region through its subcontract arrangement with the Prime? If so, what portion of health care risk would be acceptable?)

RESPONSE: Repeat of question 536.

540. We assume under subsection L.11.c that an Offeror who is awarded a Prime contract in one Region is eligible to serve as a subcontractor in another Region. Is this correct?)

RESPONSE: Repeat of question 534.

541. What percentage of ownership, control or management constitutes ownership, control or management for purposes of the "related entity" definition in subsection L.11.c.?

RESPONSE: Please see the response to Question # 11.

542. Subsection L.11.c. provides that a related entity includes an Offeror, its parent or subsidiary, or a company directly related to the Offeror through "common ownership, control or management by a parent company" (emphasis added). We understand that this section would not prohibit an Offeror (who is not a parent company) who is awarded a Prime contract in one Region from retaining partial ownership or exercising partial control or managment of an entity who is awarded a Prime contract in another Region. Is this correct? In other words, is it only if a "parent company" owns, controls or manages the entity that subsection L.11.c. applies to bar the award of a second Prime contract?

RESPONSE: Please see the response to Question # 11.

543. C-7.1.2 - MTFs referring a Prime beneficiary to a non-network provider must seek approval from the MTF's Regional Director. Is this strictly a MTF-Regional Director interaction that occurs before the referral is sent to the MCSC?

RESPONSE: Yes

544. Does TMA envision any assistance to MCSC's in mandating electronic submission of claims from high volume providers as envisioned in Section 727 of Public Law 106398 (Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001)? Will TMA define a high volume provider?

RESPONSE: ***revised 20 September 2002***

RESPONSE: Yes, a high volume provider submits 100 or more claims per month. This definition will be added to the TOM, Addendum A, in a future amendment. We assume that the majority of "high volume providers" will be in the contractor's network who are required to submit all claims electronically, but the provider demographics and populations in each state/region will determine if this is correct. TMA has no plans to assist the contractor in fulfilling this requirement.

545. Section G-3.b(1)(c). This section states that the contractor can submit to the MTF an invoice of accepted TED records. It goes on to state that TMA will provide the MTF with regular daily postings of data by DMIS ID to use to verify the contractor's invoice. Does this mean that the MTF will automatically process the contractor's invoice for payment? If the answer is no, under what circumstances can the MTF reject records that have passed the TED edits and have been accpted by TMA?

RESPONSE: ***revised 20 September 2002***

RESPONSE: A future amendment will provide revised language for Section G-3b(1)(c) that clarifies the invoicing process.

546. After the MTF receives an invoice from the contractor of accepted TED records, how long does the MTF have to review, accept and pass the invoice to DFAS for payment? If there is no mandated schedule for the MTF, what recourse does the contractor have if these invoices are not processed timely?

RESPONSE: ***revised 20 September 2002***

RESPONSE: A future amendment will provide revised language for Section G-3b(1)(c) that clarifies the invoicing process.

547. G-3a(3)(1)[1]. This section states that payment of underwritten health care costs claims will be reimbursed after the associated TED records clear all edits. Since the TED system does not currently exist will the implementation of the first contract be delayed if TEDs is not ready in time, or will the HCSR system be substituted until TEDs is ready?

RESPONSE: The TED system will be implemented on time.

548. Section C-7.1.16 states that the contractor shall ensure that network specialty providers provide specialty care, consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primay care manager within five

working days of the specialty encounter 98% of the time. In emergency/urgent situations, an additional requirement would be a preliminary report within one hour.

Question: Does TMA assume that the contractor will have a system that allows them to know when and if the appointment was kept in order to ensure meeting the consultation or referral report requirement? Does this system include the possible option of the contractor making these appointments for the beneficiary?

RESPONSE: The offeror must propose a system that meets the full intent of this requirement. Appointment activities are not a part of this contract.

549. Section C-7.1.16 states that the contractor shall ensure that network specialty providers provide specialty care, consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primay care manager within five working days of the specialty encounter 98% of the time. In emergency/urgent situations, an additional requirement would be a preliminary report within one hour.

Question: For the operative report and discharge summary requirements, the time options for completing these reports given providers by institutional Medical Staff Bylaws may impact in a non-emergent/urgent scenario. How will this be addressed relative to contractor compliance with the standard?

RESPONSE: ***revised 20 September 2002***

RESPONSE: The offeror must propose a system that meets the full intent of this requirement. A future amendment will make the change that allows the reports to be submitted within 10 working days and for urgent situations, 24 hours unless best medical practices dictate less time is required for a preliminary report.

550. It is our understanding that currently not all Prime Contractors administering MCS contracts are insurance companies licensed in the state for which they provide services. Therefore, we assume that there is not a requirement that an Offeror be a licensed insurance company as defined by the various State Insurance Commissions. Is this correct?

RESPONSE: The preemption statute states "a law or regulation of a State or local government relating to health or dental insurance, prepaid health plans, or other health care delivery or financing methods, shall not apply…." It is reasonable to assume that the requirement of business licensure is "a law or regulation…relating to health insurance…" It would be quite burdensome for our offerors to be licensed as an insurance company in every state in which they may do business under the TRICARE contracts. However, it is also reasonable to expect offerors to be licensed in at least one state, such as the state that they incorporate in, and comply with that state's licensure laws.

551. Reference Sections H-5.d; H.11.b.(1)(a) ;H.11.b.(1)(d)[2]; and I.101. 52.216.7, Allowable Healthcare Cost and Payment, (d) of the RFP - the bidder appreciates that the annual audit of "Allowable HealthCare Costs" will no longer include denied claims. The bidder would also agree that "net" claims overpayments determined from a statistically valid sample may be used to determine "unallowable costs." However, it is not a common actuarial, accounting, nor auditing practice to utilize identified overpayments while ignoring underpayments as is proposed in this RFP. In addition, it is not a "best business practice" either. Further, this statement is

in conflict with I.101. 52.216.7, Allowable Healthcare Cost and Payment, (d). The bidder requests that both overpayments and underpayments of non-denied (paid) claims be "netted" for the calculation. In the unlikely event that a net underpayment would occur, the bidder agrees that no financial impact to allowed healthcare costs should occur.

RESPONSE: *Revised 28 October, 2002.*

RESPONSE: The request for a change in the requirement has been considered by the Government. Please see our response to Question 85.

552. Reference Sections H-1. a.(1); L.12.e.(2)(f); L.12.e.(3)(e); and Attachment L-1 of the RFP - the Government clearly intends to "carve out" Medicare Dual Eligible (mostly TRICARE for Life) claims into a separate claims processor only contract. In order to avoid significant administrative costs related to "cloning" Medicare procedures (Assessments) for SNF-PPS and HHA-PPS, in the existing Contracts TMA agreed to the use of the MCS Contractor's managed care systems to achieve this same purpose. How does the Government intend to handle Medicare Dual Eligible SNF-PPS and HHA-PPS authorization issues in a primary liability situation in a claims processor only environment?

RESPONSE: This question is outside of the scope of this contract.

553. NCQA allows a health plan to not report some measures if the plan performed well on those measures in prior reporting periods. Will TMA follow NCQA practice in this regard?

RESPONSE: Please refer to the answers to Question 371.

554. Does the Government plan to provide all the Case Management within the MTF?

RESPONSE: No. We are not requiring the contractor to perform case management for the MTF but do require a coordination effort. What the RFP does say for medical management is that the contractor shall operate programs designed to manage the health care of individuals with high-cost conditions or with specific diseases for which proven clinical management programs exist. These programs shall be available to TRICARE eligible beneficiaries and active duty personnel whose care occurs or is projected to occur in whole or in part in the civilian sector. When care occurs within an MTF, the contractor is responsible for coordinating the care with the MTF clinical staff as well as the civilian providers.

555. In the response to question #14 that was posted on the TNex website on August 19, 2002, the government stated it will review each existing Resource Sharing agreement to determine its value and, if value exists, the government will consider obtaining the services under a new Resource Sharing agreement or *though a mechanism outside of this solicitation.* We assume the last section contemplates a direct contract with an unrelated third party. Will the cost of these direct contracts count toward the TRICARE contractors actual healthcare costs? If they do, will the cost include any MTF marginal costs associated with the initiative? If either cost is charged to actual health care costs, how will the contractor be protected from expenditures that might not achieve savings over purchased care costs?

RESPONSE: The cost of these direct contracts will not count toward the TRICARE contractor's actual costs.

556. Under the current MCS contracts, MTF commanders have the ability to request that all or a portion of the MTF appointment setting be performed by the Managed Care Support Contractor. Will this continue to be an option for the MTF commanders as part of this solicitation?

RESPONSE: No

557. Policy Manual Chapter 7,Section 8.1 speaks to the Audiology Services that will be covered under the new contracts. It includes CPT codes 92506 - 92551 and 92551 - 92599. CPT codes 92590 - 92599 represent procedures relative to audiometry for hearing aid selection. Policy Manual Chapter 7, Section 8.2 limits Hearing Aid Services (CPT Codes 92590 - 92599 to eligible beneficiaries of the PFPWD program. Will CPT Codes 92590 - 92599 be a covered benefit for anyone with an auditory condition as specified in Section 8.1 or are they restricted to PFPWD participants only?

RESPONSE: Policy Manual Chapter 7,Section 8.1 applies to both the Basic Program and the PFPWD, so its procedure code range is all-inclusive, while the procedures listed in Policy Manual Chapter 7, Section 8.2 are restricted to the PFPWD. A beneficiary may chose from which program to receive a service if it's covered by both policies.

558. Policy Manual Chapter 7, Section 8.1 indicates that auditory services for the diagnosis and treatment of an auditory condition is a covered benefit. Please define "auditory condition" and specifically address whether these services are covered for beneficiaries suffering from hearing loss due to aging or military service-connected environmental exposure.

RESPONSE: TRICARE has no formal definition but generally, an auditory condition is any condition involving, or related to, the auditory system and its functioning. Services are not categorized by age or service experience. Please refer to 32 CRF 199.4(g)(45), which states services of an audiologist or speech therapist are excluded unless prescribed by a physician and rendered as part of a treatment addressed to the physical defect itself and not to any educational or occupational deficit. A diagnostic test would have to be performed and covered to determine whether or not there is an auditory condition, regardless of whether or not the program will pay for subsequent treatment.

In PFPWD, the 32 CFR 199.5 establishes hearing loss as a qualifying condition for the PFPWD, but certainly there can be problems with the auditory system outside those limits for which services would be covered, such as a diagnostic test.

559. Reference H-1.a.(1) and H-1.b.(5)

a. Will Tricare Prime Remote family members be included in the actual underwritten healthcare costs?

RESPONSE: Yes

b. Will SHCP claims be included in actual underwritten healthcare costs?

RESPONSE: No

560. L.12.f(2)(i): We assume that the findings and final reports that the government requests in this section pertain only to the government accounts requested in L.12.f.(2)(d). Please note that certain reports may contain over 1,000 pages (for example, Medicare's Contractor Performance Evaluation Program). Would the Government prefer a summary of the reports rather than the actual reports?

RESPONSE: The assumption is incorrect. The RFP requires all reports. For example, state insurance commissioners issue reports not necessarily related to any specific account. We are aware of the size of the Medicare reports. Please submit the entire report including any summary.

561. Will the contractor have query capability to New DEERS to identify non-payers (split enrollments)? If not, what method or system will be available to identify non-payers?

RESPONSE: If the question is whether the MCSC will be able to identify those enrollees involved in a "split enrollment" situation, the answer is yes. MCSCs will be able to see all enrollees associated with a family, including those that are enrolled in a different region, through DOES. MCSCs should set a fee waiver for a person that is a "free-rider" in a split family situation. A "free-rider" is an individual whose fees were paid under a family policy in one contract region but are living and enrolled under a single policy in another contract region. An individual attending college in another contract region is an example. DEERS also supports a fee exception reason code that should be set by a MCSC if fees for a policy are are less than the expected amount due to a family situation.

If the question is whether the MCSC will be able to generate ad hoc reports from DEERS that identify all of the people who haven't paid enrollment fees (non-payers) , the answer is no. MCSCs should be able to identify those enrollees that have not paid fees from their own fee tracking systems. It should be remembered that all of the fee information submitted to DEERS through DOES is returned to the MCSC through EITs which can then be used to populate the contractor's fee tracking systems. MCSCs are responsible for determining if an enrollee should be disenrolled for a failure to pay fees. MCSCs should also remember that when they use their own system to determine failure to pay fee situations, they may only have a subset of information since a fee could have been paid to another contractor. MCSCs can only see these situations in DOES. As a result, an MCSC cannot automatically determine if a person should be disenrolled based only on looking at their own system. DEERS will perform an edit in the batch failure to pay fees process and not disenroll a person if DEERS shows that a fee has been paid or that there is a waiver. MCSCs should research those rejected disenrollments in DOES to determine if they still wish to perform the disenrollment.

562. C-7.14 States “The contractor shall accept payment of enrollment fees on a monthly, quarterly, or annual basis. The contractor shall provide beneficiaries with written notice of payment due and when beneficiaries are delinquent.” The Operations Manual, Chapter 6, Section 1., 8.1 Monthly Payment Fee Option - indicates that for monthly payments: “The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT.” We assume

the Operations Manual is correct and that no monthly invoicing is needed for payments through allotments or EFT. Please clarify.

RESPONSE: ***revised 13 September 2002***

The Operations Manual is correct. Monthly invoicing for payments set up under allotment or EFT is not required.

563. C-7.11 The Universal Enrollment Form does not include a waiver of access standards for beneficiaries who reside outside of a Prime service area, or even mention of the waiver on the form. If this is an oversight, will the Government revise the Universal Enrollment form to include requiring the enrollee who resides outside of the Service Area to sign the waiver of access standards?

RESPONSE: Your suggested change will be considered. Until such time as a change is published, offerors must develop another method for requiring beneficiaries residing outside of a Prime service area to waive access standards.

564. In section C-7.1.10, as a condition of participation in the contractor's network, all providers shall submit all claims electronically. The Regional Administrative Contracting Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception. After participating in a briefing provided by TMA, we were told that CHCS and CHCS II were far in advance of the civilian sector in this area. It is also our understanding that a large number of civilian providers do not have the capability to submit claims electronically. Further, many of these are in rural and under served areas where there are few TRICARE eligibles.

RESPONSE: We understand your concern; however, it is clearly in the best interest of the Government to require network providers to submit claims electronically. Since networks only exist where there is a concentration of TRICARE beneficiaries and since the standard of practice has moved and continues to move toward the electronic age, we believe this requirement is appropriate.

a. If that is true, is it realistic to expect these civilian providers to be able to fulfill this requirement?

RESPONSE: We believe that it is realistic and that the requirement can be met.

b. If so, what are the requirements the provider must fulfill regarding the security of their computer systems?

RESPONSE: Providers must comply with the HIPAA Privacy Regulations and the TOM, Chapter 21. When the HIPAA Security Regulations are published, providers will be expected to comply with those requirements. Until then, providers should continue to apply best commercial practices for keeping their medical and patient records, in all forms, secure.

c. Who provides the civilian providers with the software?

RESPONSE: It is up to the contractor to determine how its providers obtain software. Offerors shall propose their best practices for fulfilling the Government's requirements.

565. In section C-7.1.16, urgent/emergent situations that prompt a specialty consultation, requires the specialist to provide a preliminary report to the beneficiary's PCM within one hour. Since emergent care is often provided during off hours and in emergency rooms, is a one-hour turn around reasonable time to comply?

RESPONSE: ***revised 20 September 2002***

RESPONSE: We have listened to industry and in a future amendment, we will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

566. Section C-7.3.1 gives the MTFs the right of first refusal for all referrals. Does this apply to TRICARE Standard patients using network providers (which I assume makes them Extra patients)? If so, does the patient have the right to refuse the referral and select another provider?

RESPONSE: Yes, this provision refers to all beneficiaries for which the MCSC can control the referral process. Since there is a requirement for the MCSC to manage their network to achieve the Best Value Health Care for the Government and our beneficiaries, this provision applies in the situation presented. Prime, Extra, and Standard beneficiaries may refuse the referral (unless an NAS is required) and seek care from a civilian source (POS applies where applicable). However, the MCSC is required to develop practices to eliminate this situation.

567. Section C-7.4 calls for the contractor to ensure that care provided, including mental health care, is medically necessary and appropriate and complies with the TRICARE benefits contained in 32 CFR 199.4 and 199.5, for beneficiaries not enrolled in an MTF. For clarification purposes, does this provision apply only to those beneficiaries enrolled in TRICARE Prime, though not at a MTF only?

RESPONSE: No, the provisions of 32 CFR 199 apply to all services funded through TRICARE. The point of RFP Section C-7.4. is that care referred/authorized by the MTF has passed the medical necessary and appropriateness test.

568. Section C-7.21.10 requires that the contractor shall ensure that an adequate audit trail is maintained for all returned or denied claims. Will there be a standard policy for all three contractors? If so, what is the policy and will there be date stamping as each step is taken?

RESPONSE: No, we believe that this is an excellent opportunity for offerors to employ their best practices in fulfilling the requirement.

569. There appears to be no change in the requirement for non-availability statements or pre-authorizations for TRICARE Standard patients. Does the RFP allow for the elimination of non-availability statements and pre-authorizations for TRICARE Standard Patients?

RESPONSE: Please refer to the TRICARE Policy Manual for NAS requirements. Preauthorization, with those few exceptions (i.e. inpatient mental health, PFPWD, etc) will be based on the best practices proposed by the offeror.

570. C-7.42. Requires the contractor to provide pharmaceuticals to beneficiaries in situation where the pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under an outpatient pharmacy benefit. The paragraph then lists when the contractor is not at risk for pharmaceutical costs. Could you please cite an example or two when the first situation may occur?

RESPONSE: Examples may include the administration of chemotherapy in a provider's office or clinic, and IV antibiotic therapy delivered by a home infusion service as part of the Home Health Care benefit.

571. L.12.f.(2).(b) requests a maximum 25 page description of experience a bidding prime and first tier contractor(s)may have had with similar type MCS contracts. The article stipulates that only experience gained within the past three years will be considered by the Government. While realizing the Government is most interested in current, or very recent performance, it seems that this three year restriction precludes almost anyone but current contractors from addressing this specific item. This restriction seems to favor current contractors over others. How does a bidding contractor who provided excellent services as late as 1996 get credit for those services?

RESPONSE: In the first sentence, you have misquoted Section L-12f(2)(a) as we are looking for broader relevant experience. We disagree with the assertion that only current MCSCs will have experience in the last 3 years. Relevant experience includes experience in the delivery of the services required by this contract which is a much larger universe than TRICARE.

572. Reference Section C-7.1.16 of the RFP - the following questions pertain to the requirement that contractor's ensure that network specialty providers provide consultative reports to the beneficiary PCM within five working days of the specialty encounter 98% of the time.

a. Are referrals to non-network providers that are approved by the MTF's Regional Director (per C-7.1.2) exempt from the five-day consult return standard?

RESPONSE: Yes

b. When the beneficiary involves his/her right to use Point-of- Service (POS), is the referral exempt from the five-day consult return standard?

RESPONSE: Yes, because no referral exists.

c. Are providers associated with any Federal health care system (MTF, VA and Indian Health Service) excluded from the five-day consult return standard?

RESPONSE: When these providers are network providers, the requirement applies.

d. The government standard for the return of specialty consults is 98% within five days. However, the urgent/emergent situation calls for a preliminary report within

one hour. What is the government standard compliance rate for urgent/emergent situations?

RESPONSE: ***revised 20 September 2002***

RESPONSE: We have listened to industry and in a future amendment at their suggestion based on their experience, we will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

573. Reference Section C-7.1.2 of the RFP - the following questions address the requirement that the MTF only refer their TRICARE Prime enrollees to non-network civilian providers when it is clearly in the best interest of the Government and the beneficiary. Approval from the Regional Director is required.

a. Will these approved non-network referrals will be submitted to the contractor electronically?

RESPONSE: Yes, via an ACS X12N 278 transaction.

b. Will these approved non-network referrals from the MTF providers be excluded from the Performance Guarantees Calculation at H-8.1? If not, can the government estimate (by volumes or %) what portion of the 4% acceptable non-network workload will be generated by MTF-PCM (and approved by the Regional Director)?

RESPONSE: ***revised 20 September 2002***

RESPONSE: Approval by the Regional Director will be eliminated in a future amendment. MTF referrals to non-network providers are included in the Performance Guarantee calculation as it would be infrequent that they would occur.

574. Section J, attachment 2 gives the beneficiary the choice of paying their enrollment fees with payroll allotment, auto debit of their bank account, and auto charging their credit card in addition to the current methods of check and credit cards. These options provide the beneficiary with the ease and convenience of the payment options they are used to, but also three new ways of paying their enrollment fees. From the contractor's standpoint, auto debit, payroll allotment, and auto credit have never been required on current MCS contracts, and will prove to be costly whether the additional services are performed in-house, or by a third party vendor. Is there any printed guidance on these payment methods in the TRICARE Operations Manual as to how these transactions are to be performed in a uniform manner? At one point, there were discussions of using a consolidator to perform some of the above collection methods. Please advise.

RESPONSE: The TRICARE Manuals do not include guidance on this customer oriented commercial practice. There is no consolidator included in this RFP.

575. Operations Manual - Chapter 12, Section 5 references 1-800 TRICARE. It is assumed that each contractor will have a regional toll-free number as well. Is this assumption correct?

RESPONSE: Yes, offerors must propose contemporary means of access for all TRICARE customers.

576. Please clarify the start-work dates in relationship to two of the stated requirements in the Operations Manual. Chapter 12, Section 5, 3.0 Telephones indicates that calls shall be routed to the incoming contractor no later than 150 calendar days prior to the start of health care delivery. Chapter 1, Section 8 Transition 4.4.3.3 indicates that "The outgoing contractor shall vacate the TRICARE Service Center on the 40th calendar day prior to the start of health care delivery. Is the intent to have the outgoing contractor continue the provision of walk-in services after the incoming contractor's call in-take units have begun operations?

RESPONSE:

1. The start work dates may be found in the response to question 451.

2. OPM Chapter 12, Section 5.3.0 requires only that the incoming contractor shall provide the telephone number to the CO no later that 150 days prior to the start of services delivery, not that the incoming should start providing telephone services at that time.

3. Chapter 1, Section 8 - The incoming contractor will take over and operate the TSCs from the 40th day prior to the start of health care delivery. This includes answering the phone. At that same time, the outgoing contractor will vacate the TSC but will maintain their central health care finder functions and continue to operate their central customer service telephone lines. The outgoing contractor will no longer provide services to walk-ins at the TSCs. The incoming contractor will, from day 40 prior to the start of HCD, assist walk-in beneficiaries with all issues, including helping them get in touch with the outgoing contractor, if appropriate.

577. The marketing contractor will price a finite number of marketing pieces - handbooks, brochures, flyers, etc. in that contract. The healthcare contractor will determine via MOU with the marketing contractor not only quantity, frequency and content of those specifically identified marketing items, like the beneficiary newsletter, but also additional items not specified by the marketing contractor. Who should plan to pick up the cost of these items specified in the MOU?

RESPONSE Revised 12 November 2002

RESPONSE: In a future RFP amendment the contractor will be directed to establish the MOU with the Government for quantity, frequency, types, and distribution points for materials. Additional materials not listed in the MOU may be requested through TMA, Communications and Customer Service Directorate (C&CS). C&CS will provide the materials ready for distribution at no cost to the MCS contractor. The MCS contractor will be responsible for the cost of distribution.

578. Reference Section C-7.21.2 of the RFP - what is meant by program administration data? What is the minimum requirement to provide data in this category?

RESPONSE: Examples of program administration data could be the work flow between the organization work units, reasons why claims are suspended, the organizational structure and any announcements of change, decision documents that

are not proprietary, etc. The minimum data elements will be established based on the offeror's proposal.

579. In previous MCS contracts, the McNamara - O'Hara Service Contract Act (SCA) was a requirement and listed in Section I. According to the U.S. Department of Labor SCA Resource Book (4/98) "The SCA was intended to remove wages as a factor in the competition for federal service contracts by requiring the payment of not less than the locally prevailing wage rates (not the FLSA minimum wage) and fringe benefits, or in certain cases, the wage rates and fringe benefits contained in a predecessor contractor's collective bargaining agreement (section 4(c) of the Act). (Labor costs are often the predominant factor affecting bids on service contracts being awarded to the lowest bidder.)"..." Section 4(c) was added to the Act in 1972 in response to "wage busting"...following the recompetition of several major support contracts."

a. Are the provisions of the Service Contract Act, 41 USC 351, applicable to this procurement?

RESPONSE: No

b. If the SCA is not applicable, will the incumbent contractors be at a disadvantage because they are already paying prevailing wages?

RESPONSE: The Government will not mandate wage rates in the proposed contracts.

c. If the SCA is not applicable**,** will successor contractors be required to recognize an incumbent contractor's employees' seniority or current wage?

RESPONSE: The Government will not mandate wage rates in the proposed contracts.

580. Please provide the numbers and locations of HBAs and their expected duties under the TNex contracts.

RESPONSE: HBAs are Government employees, either uniform or civilian, located at nearly every MTF. Their functions vary depending on the needs of the MTF but they are always advocates of our beneficiaries available to provide information and assistance with TRICARE. Offerors SHALL NOT assume that these Government employees will reduce the contractor's workload in any situation.

581. Can I get a list of the companies that have requested a copy of this solicitation?

RESPONSE: The solicitation mailing list is available on the TMA website

582. Is there a subcontracting opportunity for a SDB on this project?

RESPONSE: No specific opportunity has been identified, however, we anticipate there are subcontracting opportunities for small and small disadvantaged businesses. In their subcontracting plans, offerors are expected to address if there are subcontracting opportunities and their goals for subcontracting with small and small disadvantaged businesses.

583. How often are the questions updated and posted for review?

RESPONSE: Questions will be posted as soon as possible after receipt by the Government. The Government will respond to questions and post responses as soon as possible thereafter.

584. The Questions and Answers section was last updated August 19, 2002. When will the next update be? Please let me know.

RESPONSE: It is the responsibility of interested parties to monitor the web site for updates.

585. Site Visit - The Government recently announced that site visits will not be permitted prior to proposal submission. Information obtained during site visits is crucial to accurately developing, proposing, and pricing network development, resource sharing, and TSC activities. Particularly in this solicitation, which emphasizes MTF optimization as one of the most important evaluation factors, knowledge of current MTF capacity and capabilities is vital to preparing a competitive bid. Will the government reconsider?

RESPONSE: Response: Thank you for your comments. We understand the points you have outlined and have determined that site-visits to each MTF will not benefit potential offerors. However, we will be offering briefings by representatives of each of our Surgeons General that will provide an overview of the delivery of health care services by military medicine. In addition, we will offer a tour of a few facilities to provide offerors unfamiliar with military hospitals an opportunity to view different facilities. Please monitor our web site for the location, date, and time of these visits. We believe that these briefings and tours, combined with the data available in Attachment J-8 of the RFP will provide the information necessary to prepare a successful proposal. This allows for the most effective use of offeror and Government time since site visits are not opportunities for prospective offerors to propose options to the Government or to develop data that is not available in the RFP or through the formal question and answer process.

We do believe, however, that it is important to reiterate what the Government means by MTF Optimization and the expectations for resource sharing. MTF Optimization is defined in the TRICARE Operations Manual, Appendix A as "Military Treatment Facility (MTF) Optimization: Filling every appointment and bed available within the MTF with the appropriate patient based on the capacity and capabilities of the MTF and the MTF's readiness/training requirements, as defined by the MTF Commander." This is very different from and must not be confused with MHS Optimization which is a management philosophy employed by military medical leadership to manage the health of our beneficiaries while achieving our mission. The contractor role is a small piece of MHS Optimization limited to providing an adequate pool of patients to MTF Commanders. Achieving this impacts many contractor operations including, but not limited to, enrollment in both TRICARE Prime and TRICARE Plus, beneficiary education, provider education, medical management, and networks that support but do not detract from the MTF. All of this must be proposed as one or more models that also recognize that MTF capability and capacity may change on a daily basis. While we understand that there is some belief that the Government desires the MCSC to manage MTF productivity, this interpretation is incorrect. The contractor's role is limited to supporting the MTF as specified above

and in the RFP. The models required in the RFP can very reasonably and accurately be developed based on the data available with the RFP. In preparing their proposals, offerors must take into account that while the historical data reflects actual workloads encountered the data are not to be interpreted as a guarantee of future workloads to be encountered under the proposed contract.

Resource sharing is very similar. We are not asking offerors to propose specific resource sharing agreements. Rather, we are simply asking offerors to explain "how the offeror's capability to support resource sharing will enhance the MTFs capability and capacity. This description must include the criteria the offeror will utilize to determine when it will support a resource sharing request from the Government and the process the offeror will utilize to identify potential resource sharing opportunities to the Government." We believe that the model requested as part of the bid can and should be accomplished without visiting MTFs and attempting to predetermine potential resource sharing opportunities.

586. Site Visit -What latitude does the bidder have in visiting TRICARE IT staff to understand DEERS, CHCS, Duplicate Claims, etc., interfaces, data model, edits, requirements, operational schedules, etc.?

RESPONSE: We have considered your request and the agency agrees that a briefing of some of the IT features of TRICARE would be beneficial to prospective bidders. The Government will schedule a briefing for any interested party and will announce the date, time, place and agenda shortly.

587. Transition - What is required to be transitioned from the incumbent to the new contractor in regards to history (data) authorization/referral information, providers, billing information, etc.?

RESPONSE: Please review the TRICARE Operations Manual, Chapter 1, Section 8, available on the solicitation web site, for transition requirements.

588. Fact Sheet - The TRICARE Fact Sheet, which was released on August 1, discusses the creation of "local support contracts" teams to assist MTF Commanders in establishing local contracts for Health Care Information Line and appointment scheduling services. Please confirm that this means there are no HCIL or appointment scheduling service requirements for the MCS contractor to perform as part of this RFP.

RESPONSE: There are no requirements for HICL or MTF scheduling in this solicitation. Offerors may propose their best practices regarding appointment scheduling in the network.

589. Substance Abuse - There appears to be no reference to outpatient services in lieu of inpatient hospitalization for substance abuse. Is this a benefit option?

RESPONSE: Please see 32 CFR 199 and the TRICARE Policy Manual, both available on the solicitation web site, for a complete discussion of the TRICARE benefit.

590. Certification/Audits - When are the DOD certifications required to be completed? At RFP submission? 2 months prior to going live? At Day 1, go live date?

RESPONSE: Please clarify to what DOD certifications you are referring to.

591. Miscellaneous - Where are the references to Health Care Service Records (HCSRs)? Is there still a requirement for them?

RESPONSE: No, the HCSR was replaced by the TED. Please see the TRICARE Systems Manual, available on the solicitation web site, for detailed information.

592. Miscellaneous - If the MTF refers to a non-network civilian provider, does that count against the performance guarantee of 96% in network care delivery?

RESPONSE: Yes, an MTF Commander being forced to refer a patient to a non-network provider is a reflection on the adequacy of the contractor's network.

593. Miscellaneous - Will the government provide detailed information on Specialty Treatment Centers, i.e., the type of specialty care provided (by ICD-9/DRG code), referral volume and source, workload activity, and number of non-availability statements; number of referrals that did not receive care at STC and reason?

RESPONSE: We assume that you are referring to the TRICARE designated Specialized Treatment Service Facilities as referenced in the current Operations Manual, Chapter 19. This program will terminate no later than May 31, 2003 therefore these facilities not a part of this contract. However, the HCSR data code for this information is "Type of Institution" Code 71. The only available data for STCs is included in the data tapes available for purchase with this solicitation. We have no available data on the referral patterns.

594. C-7.1.3 How are we to handle catchments areas and other potential network sites where the population of practicing/available MDs is so small that we cannot find/assure sufficient quantity and diversity to meet access standards for the MHS Medicare population?

RESPONSE: The Government expects offerors to propose their best practices for achieving the contract requirements. The Government's expectation is that these practices will allow offerors to fulfill the Government's requirements.

595. C-7.1.10 - Requires all network providers to submit all claims electronically, however, many providers do not have internet access within their offices. The requirement does allow for exceptions to be granted by the Regional Administrative Contracting Officer based on a fully justified written request. Will the Regional Administrative Contracting Officer be prepared to handle the volume of requests for exceptions?

RESPONSE: The Government is prepared to handle exceptions.

596. C-7.1.1 - This section includes specialty consultation reporting requirements that do not conform to any current commercial practice and would result in a significant increase in provider frustration; they would rank high on the "provider hassle" scale. Further, the requirement for urgent/emergent specialty consultations to be conveyed to the beneficiary's primary care manager within one hour implies that the primary care manager is responsible for coordinating care in urgent and emergency situations, which conflicts with the right of a patient to receive emergency care as medically necessary and appropriate. Additionally, these

requirements would add significant administrative burden and cost to the program without commensurate benefit. Most importantly, these requirements would have a negative impact on the ability to meet Objective 2 of the RFP – maintaining the highest levels of beneficiary satisfaction. Beneficiaries frequently cite a desire to have a robust network of providers, yet these requirements would serve as a disincentive for providers to participate in the network. Can the contractor propose a less costly and burdensome approach to meeting the objectives of this requirement?

RESPONSE: ***revised 20 September 2002***

RESPONSE: We believe correct section is Section C-7.1.16. We have listened to industry and in a future amendment, the requirement for referral reports to be reported within 5 working days will be amendmened to 10 working days. In addition, we will change the 1 hour preliminary reporting requirement for preliminary referral/consultation reports to being required within 24 hours unless best medical practices require a quicker response time.

597. C-7.1.16 - Mental health providers usually are not considered specialty providers in commercial health care programs. Does the government consider mental health providers to be specialty providers and does this requirement apply to them?

RESPONSE: Yes and Yes

598. C-7.1.16 - Please clarify the definition of "consultation." Should the contractor assume that consultation includes only CPT codes 99245 through –99 or are there other CPT codes that should be included in the definition of consultation?

RESPONSE: A consultation is defined as any professional service requested by the primary care clinician to assist in the diagnosis of treatment of a patient. CPT codes 99241 through 99275 should be included in the definition of consultation.

599. C-7.18 - What are the minimum qualifications of the Health Care Finder? Please clarify the requirements in this solicitation.

a. To be described in the UM Plan (OPM, Ch. 7, Section 1, subsection 1.2)

b. Referenced in extremely general terms in OPM, Ch. 12, Section 3, subsection 1.0

RESPONSE: Health care finder qualifications are to be proposed by the offeror based on the tasks these individuals will accomplish.

600. C-7.2 - Will the receipt of the network specialty provider's consultation report be captured in CHCS II for purposes of auditing the return of all required information within the standard?

RESPONSE: No